ORTHOPEDICS REFERRAL FORM

Referral Process

1. Please complete the form below for all GENERAL ORTHOPEDIC concerns. **There is a separate form for fracture/injury referrals.** Please be as detailed as possible. If there is not enough detail, the referral will be denied. Feel free to add a letter to support this form. **Areas with an * must be filled/checked.**
2. Inform the patient/family that **CHEO will contact them** to setup an appointment time.
3. Fax this completed form to **613-738-4865**.

*If applicable, **please provide the patient with any medical imaging** (unless on NEODIN/CNER) and advise to bring to their appointment.*

Patient Information – PLEASE PLACE PATIENT LABEL OR PRINT CLEARLY

*Name		*Referring Hospital Name	
*DOB (dd/mm/yyyy)		*Referring Provider	
*Phone #		*Provider Billing #	
Address			

Reason for Referral

☐ **Spine Deformity**	☐ Scoliosis *Cobb angle(s): _____ ☐ Spondylolysis ☐ Kyphosis	**All referrals must include an X-ray report indicating the Cobb angle measurement(s) of the curve(s).**
☐ **Hip** ***Please Note for stable hips:*** - ***If screening for breech or positive family history, please order ultrasound and refer if abnormal.*** - ***Under 6 months old (ultrasound required @ 6 -8 weeks of age – please obtain and include report)*** - ***Over 6 months old (x-ray required – please obtain and include report)***	☐Developmental Dysplasia of the Hip (DDH) ☐ Unstable hip(s) ☐ Stable hip(s) ☐ Perthes Disease ☐ SCFE **(This is a medical emergency, page Ortho resident on-call or send to Emergency Room)** ☐ Other: _____	

☐ **Lower Extremity**	***Please Note:*** *Genu valgum and Genu varum are part of normal physiologic development of the lower limbs. Genu varum should resolve before 3 years of age and genu valgum by age 7. Persisting deformities warrant referral for surgical opinion. If concerned before these ages, please complete e-consult prior to formal referral.* ☐ Leg Length Discrepancy (over 2 cm) ☐ Genu valgum (knock knees) ☐ Genu varum (bow legs over 2 years of age) ☐ Congenital Deficiencies (femoral or tibial)
☐ **Foot and Ankle**	***Please note:*** *We will only accept In-toeing referrals after the age of 7 and Toe Walking referrals after the age of 3. All patients referred for Toe Walking must complete 6 months of Physiotherapy prior to consultation. Please re-refer if no improvement or progression after trial of Physiotherapy.* ☐ Club Foot ☐ Tarsal Coalition ☐ In-toeing (after 7 years of age) ☐ Vertical Talus ☐ Bunion ☐ Toe Walking (after 3 years of age) ☐ Cavus Foot ☐ Toe Abnormalities ☐ Physiotherapy complete ☐ Painful Flatfoot
☐ **CP/Neuromuscular**	***New Ontario CP diagnoses should be referred to Access Team at CHEO.** **Diagnosis:** ☐ Cerebral Palsy ☐ Spina Bifida ☐ Other Neuromuscular **Type:** ☐ Hemiplegia ☐ Diplegia ☐ Quadriplegia ☐ Other ☐ Unknown GMFCS Level (if known): _____ **Reason for Referral:** ☐ Spinal Deformity ☐ Hip Problem ☐ Lower extremity problem ☐ Foot problem ☐ Gait concern Notes:_____ _____
☐ **MSK Tumor**	☐ Malignant/Suspected Malignant or lesion ☐ Benign/Unknown tumor or lesion Please include all imaging reports and a detailed history and physical
☐ **Other**	_____